

Application For Professional Liability Insurance  
for Physicians and Dentists

Proposed Coverage Effective Date \_\_\_\_\_

## Section 1: General Information

1. Full Name of Applicant \_\_\_\_\_ MD DO DDS DDM Other \_\_\_\_\_
2. Date of Birth \_\_\_\_\_
3. Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_
4. Organization Name \_\_\_\_\_ Tax ID # \_\_\_\_\_
5. Type of Practice Solo Unincorporated Provider Individual(solo) Corporation Partnership Member of Multi-person Corporation  
Employee of \_\_\_\_\_ Independent Contractor of \_\_\_\_\_ Other \_\_\_\_\_
6. Principle Business Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
County \_\_\_\_\_ Email Address \_\_\_\_\_ Web Address \_\_\_\_\_
7. Is billing address different from principal business address? If yes, please list.  
\_\_\_\_\_  
\_\_\_\_\_
8. Administrator Contact at Business Name \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_

## Section 2: Provider Information

Answer each question. For all YES answers, please explain in space provided or by attachment.

9. Describe the professional activities for which you are requesting coverage

Specialty \_\_\_\_\_ Sub-specialty \_\_\_\_\_

Have you ever:

- a. Been the subject of investigative or disciplinary proceedings or reprimand by a governmental or administrative or licensing agency, hospital, or professional association?
- b. Been charged with or convicted of an act committed in violation of any law or ordinance other than traffic offenses?
- c. Had any state professional license or license to prescribe or dispense narcotic refused, suspended, revoked, renewal refused, restricted or accepted only on special terms?

Yes

No



	Yes	No
d. Has any insurance company canceled, declined, denied or refused to renew or placed conditions or restrictions on your professional liability insurance?		
e. Failed any medical licensing or specialty organization examination or not eligible for Boards?		
f. Been named in a claim or suit for professional malpractice, or have any judgements been made against you or any out-of-court settlements made on your behalf? <i>If yes, please complete a Supplemental Claims Information Form at the end of the application.</i>		
g. Been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management, or any other mental illness?		
h. Had or do you presently have any chronic or life-threatening physical illness or defect which affects your ability to practice medicine?		
i. Had your privileges denied, suspended, revoked, or monitored at any hospital, health program or medical facility?		
j. Are you aware of any acts, errors, omissions, or circumstances which may result in a malpractice claim or suit being brought against you, your partners, or members of you organization?		

Please explain any YES answers from above questions in space provided below or by attachment.



10. Check the procedures preformed by you.

Abortion, elective  
 Acupuncture  
 Amniocentesis  
 Anesthesia  
     Caudal  
     Conscious sedation  
     General  
     Local  
     Regional nerve block  
     Spinal  
     Other \_\_\_\_\_  
 Angiography  
 Angioplasty  
 Appendectomy  
 Arteriography  
 Arthroscopy  
 Assist in Major Surgery  
     On own patients  
     On patients of others  
 Bariatric Surgical Procedures  
     Gastric Banding  
     Gastric Bubble  
     Gastric Bypass  
     Gastric Stapling  
 Blepharoplasty  
     Cosmetic  
     Reconstructive  
 Breast Biopsy  
 Breast Implants  
 Breast Reduction  
 Cardiac Surgery  
 Cataract Surgery  
 Caesarean Sections  
 Chelation Therapy  
 Chemonucleolysis  
 Chemotherapy  
 Cholecystectomy  
 Circumcision  
 Colonoscopy  
 Colposcopy  
 Cryosurgery, other than external lesions  
 Catheterizations  
     Arterial  
     Cardiac  
     Swan-Ganz  
     Ureteral  
     Umbilical  
 Dermatological or Aesthetic  
     Procedures \_\_\_\_\_ %  
         Botox Injection  
         Chemical Peels  
         Chemabrasion  
         Collagen Injection/Derma Fillers  
         Dermabrasion  
         Fat Transfer  
         Hair Transplant  
         Laser Hair Removal  
         Laser Skin Resurfacing  
         Microdermabrasion  
         Silicone Injection  
         Spa  
         Other \_\_\_\_\_

D & C  
 Dermatopathology  
 Dialysis procedures  
 Discography  
 Echocardiography  
 Endoscopic laser therapy  
 Endoscopy  
     Cystoscopy  
     Bronchoscopy  
     EGD  
     Gastrosocopy  
     Hysteroscopy  
     Proctoscopy  
     Sigmoidoscopy  
     Other \_\_\_\_\_  
 Experimental procedures or research or drug  
 testing. (Including a copy or form used to  
 obtain informed consent) Are procedures  
 FDA approved? \_\_\_\_\_  
 ERCP/ERC  
 Exchange transfusion  
 Facial plastic surgery  
     Elective cosmetic  
     Reconstructive  
 Fluoroscopy  
 Fracture Reduction  
     Closed  
     Open  
 Hand Surgery  
 Hemorrhoidectomy  
 Hernia Repair  
 Hip Nailing  
 Hyperbaric Medicine  
 Hysterectomy  
 Injection of Radioisotopes  
 Intensive care for Newborns  
 Intensive care Medicine for Adults  
 Infertility Treatment  
     Medical  
     In vitro fertilization  
     Other surgical  
 Laminectomy  
 Laparoscopy: Certified? \_\_\_\_\_  
 Laser Surgery: Type \_\_\_\_\_  
 Lasik  
 Left Heart Catheterization  
 Liposuction  
     Tumescent  
     Other \_\_\_\_\_  
 Lithotripsy  
 Mammography  
 Medical Weight Loss Management \_\_\_\_\_ %  
 Mesotherapy  
 Myelography  
 Myomectomy  
 Neonatology  
 Normal Deliveries

Organ Transplantation  
 Orthopedic Surgery  
     Including Spinal Surgery  
     Without Spinal Surgery  
 Osteopathic Manipulative Medicine  
 Pain Management  
     Cordotomy  
     Dorsal Root Ganglionectomy  
     Facet Blocks  
     Medication Only  
     Nerve Root Blocks  
     Pump Implantation and Removal  
     Rhizotomy  
     Sphenopalatine Lesioning  
     Spinal Injections  
     Thoracic Sympathectomy  
     Trigeminal Lesioning  
     Other \_\_\_\_\_  
 Paracentesis  
 Percutaneous Vertebroplasty  
 Peripheral Nerve Surgery  
 Pacemaker Placement  
 Polypectomy  
 Prenatal Care – 1st Trimester  
 Prenatal Care – 2nd Trimester  
 Prenatal Care – 3rd Trimester  
 Prolotherapy  
 Provertin Retinal Therapy  
 Radiation Therapy  
 Radiopaque Dye Injection  
 Roux-en-Y  
 Sclerotherapy  
 Shock Therapy  
 Spinal Fusion  
 Spinal Surgery, other \_\_\_\_\_ %  
 Thoracic Surgery \_\_\_\_\_ %  
 Thoracentesis  
 Thyroidectomy  
 Tonsillectomy/Adenoidectomy  
 Transgender Surgery/Hormonal Gender  
 Conversion  
 Tubal ligation  
 Vascular surgery \_\_\_\_\_ %  
 Vasectomy  
 X-Ray Procedures  
     Noninvasive  
     Invasive  
 None of the above apply to my practice  
 (Initial)  
 Other procedures not listed above  
 (Please list)



### Section 3: Practices and Procedures

11. In what States are you requesting Inspirien to provide you coverage?

State	License #	% of Practice
_____	_____	_____
State	License #	% of Practice
_____	_____	_____

12. National Provider Identifier No. \_\_\_\_\_

13. Federal DEA License No. \_\_\_\_\_

Has your DEA license ever been restricted or revoked? Yes No

If YES, explain: \_\_\_\_\_

14. Has there been any changes in your practice or specialty in the past 5 years? Yes No

If YES, explain: \_\_\_\_\_

15. Do you perform procedures which are not included in your primary medical specialty? Yes No

If YES, explain: \_\_\_\_\_

16. Do you normally staff an emergency department? Yes No How many hours per month?

a. Is this required for staff privileges at the hospital? \_\_\_\_\_

17. Do you work part-time outside of your regular full-time practice for which you are applying by this application ("moonlight")?

Yes No If YES, describe \_\_\_\_\_

b. Is this activity insured by your part-time ("moonlighting") employer? Yes No

c. If YES, name of insurance company \_\_\_\_\_

d. If NO, how many hours do you work per month? Yes No

Do you desire this policy to extend to cover this work? Yes No

18. I practice medicine Full Time Part Time (20 Hours per week or less)

19. Are you in the employment of an individual firm or corporation other than the organization you listed in 4? Yes No

If YES, explain, giving details of your responsibilities: \_\_\_\_\_

20. Do you provide professional health care services to correctional institution inmates (i.e. federal or state prisons, county jails, or youth detention centers? Yes No If YES, please describe your duties and hours worked? \_\_\_\_\_

21. Do you provide health care services to nursing homes, assisted living, or other convalescent home? Yes No

If YES, please list name of facility \_\_\_\_\_

Do you have professional liability coverage for this exposure? Yes No With whom? \_\_\_\_\_

22. Do you or will you render medical professional services via telecommunications technology that involve patients who reside outside your primary state of practice that you are requesting Inspirien to provide you coverage? Yes No

If YES, explain and list all states and type of professional services rendered. \_\_\_\_\_



23. Do you supervise any individuals other than your own employees? Yes No

If YES, provide a detailed explanation of your responsibilities and your relationship to the entity which employs these individuals.

## Section 4: Education and Training

24. Indicate your education background (or attach a copy of your Curriculum Vitae if such information is included)

a.	Undergraduate School	_____	Year Completed	_____
b.	Graduate School	_____	Year Completed	_____
c.	Medical School	_____	Location	_____
d.	Internship at	_____	Location	_____
e.	Residency at	_____	Location	_____
		_____	Location	_____
f.	Fellowship or Advanced Training	_____	Year Completed	_____
g.	Please explain any gaps in above chronological sequence			

25. Are you a U.S. Citizen? Yes No If NO, indicate your status and date of entry into the USA

26. Are you a foreign medical school graduate? Yes No

If YES, are you certified by the Educational Council for Foreign Medical School Graduates? Yes No

27. Are you U.S. Board Certified? Yes No Specify

Organization Extending Certification \_\_\_\_\_

Are you Board Eligible? Yes No

28. Are you in your first year of practice? Yes No

## Section 5: Organization and Employee Information (Only needs to be completed once for entire group practice)

29. Legal Name of Your Organization \_\_\_\_\_

30. Date Organization was formed? \_\_\_\_\_

31. Do you desire to purchase a separate limit for your organization listed in #29? Yes No

If YES, Retroactive Date of Organization \_\_\_\_\_

\* must attach declarations page from current policy to evidence retroactive date

Do you desire to have shared limits at no extra cost? Yes No

If YES to separate limits, please list all physicians or dentist who are working for your organization, but are not applying for coverage with Inspirien Insurance Company.



## Employee Information

Certain mid-levels presents additional exposure to the practice and are not automatically covered by the policy. The types of mid-levels requiring a charge are Nurse Practitioners, Physicians Assistants, Midwives, Nurse Anesthetists, Chiropractors, Psychologists, Podiatrists. There are two ways to cover them:

1. They can share in the physician's limit or
2. You can name them on your policy and provide separate limits to each of them.

Allied Provider Name	License Type ( PA/NP, CRNA)	Hire Date	Shared or Separate Limits	Avg Hours Worked/Week	Retroactive Date*

Please attach separate roster in excel if additional space is needed for listing of names

\* Note: When separate limits are requested proof of the current retroactive date from your declaration page and a reporting endorsements (tail) will need to be purchased when they depart your employment.

## Section 6: Coverage

Limits Available : 1 Million/ 3 Million If you desire higher limits, we can provide an excess limits quote.

Please indicate excess limit desired 1 Million 2 Million 3 Million

32. Do you want a deductible to apply? Yes No If YES, check the deductible amount below  
\$5,000 per claim \$10,000 per claim Other

### Current/Prior Coverage Information

Company	Policy No.	Policy Limits	Deductible	Policy Type				Policy Period
				Claims Made		Occurrence		
				Claims Made		Occurrence		
				Claims Made		Occurrence		
				Claims Made		Occurrence		

33. Were you at any time without insurance? Yes No

If YES, please indicate on a separate sheet of paper when and the reason.

34. Are you requesting prior acts coverage? Yes No If NO, skip the section 34a.

Retroactive date requested (this date should match the retroactive date on your current professional liability policy)

Prior acts coverage is not automatic and is subject to underwriting approval. Because you are requesting coverage on a claims-made basis you will either need to purchase a reporting endorsement from your prior claims-made insurance carrier or request we provide you with prior acts with the same retroactive date that is on your expiring policy. If you do not purchase a reporting endorsement or request prior acts coverage, professional healthcare incidents that occurred prior to the date you are applying to this coverage will no longer be covered. The ability to purchase a reporting endorsement is time sensitive and typically needs to be done within 30 days of your policy cancellation date.



- a. If you are applying for prior acts answer the following questions regarding adverse patient outcomes which may have occurred in your practice in the last two years which you have not already reported to your current professional liability insurance company. Any YES answer must be reported to your current insurance carrier prior to your coverage being offered.
- |    |   |     |    |
|----|---|-----|----|
| 1. | Since the retroactive date listed above has your practice or coverage changed? (Different limits, different states, Different procedures)   | Yes | No |
| 2. | Fetal distress during labor and delivery, newborn Apgar score less than six at either one or five minutes, or evidence of neurological or physical compromise of an infant?   | Yes | No |
| 3. | Any UNEXPECTED death (including stillbirths), organ failure (heart, liver, lung, kidney), or any significant neurological or functional deficit, or intractable pain, following surgery which were not present upon admission, which are not explained by the medical condition and/or general health of the patient? | Yes | No |
| 4. | Any alleged failure or delay to diagnose a condition resulting in death or serious permanent disability, or any delayed communications of positive diagnostic imaging or pathology reports?   | Yes | No |
| 5. | Contact by an attorney either requesting records of a patient or notifying you that a malpractice action is being investigated or contemplated  | Yes | No |
| 6. | Any acute myocardial infarction, arrest, embolism, aneurysm, or cerebral vascular accident during or within 48 hours of surgery or 72 hours of an office visit?   | Yes | No |
| 7. | Any admission or return to the ER/OPD within 5 days of treatment due to complications from surgery resulting in serious temporary or permanent injury or death?   | Yes | No |

**APPLICATION MUST BE SIGNED AND DATED BY THE PROVIDER REQUESTING COVERAGE.**

Signing this application does not bind Inspirien Insurance Company to provide coverage, but it is agreed that this form is to be included with other information which shall be the basis of the contract should a policy be issued to the undersigned. Furthermore, should the undersigned withhold important information, supply misleading information, or attempt to defraud or attempt to defraud or lie to Inspirien Insurance Company about any matter contained in this application, then coverage provided by virtue of this application is void. **Any Person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.**

Date \_\_\_\_\_ (x) \_\_\_\_\_  
 \_\_\_\_\_  
 (Applicant Signature)  
 \_\_\_\_\_  
 (Printed Name)

**THE FOLLOWING IS REQUIRED WITH THE APPLICATION**

- Your expiring insurance policy Declarations Page showing Retroactive Date
- Current CV (curriculum vitae – also known as a resume)
- Current dated Loss Run report from all Prior Insurance Companies over the last 5 years or length of practice if less than 5 years.



Inspirien Insurance Company  
Authorization for Release of Information

I, the undersigned, have provided Inspirien Insurance Company (Inspirien) information in their insurance application in order for Inspirien to evaluate my insurability under their policy of insurance.

Therefore, I hereby authorize all persons, firms, corporations, including, but not limited to, prior liability carriers, hospitals and their officers, directors, medical staff, and employees, medical association, medical society, the State Board of Medical Examiners for any state in which I have practiced and any other entity, either public or private, to provide Inspirien with any information, whether written or otherwise, which may be material to evaluating my application for insurance with Inspirien. Furthermore, I release any of the above or their agents from liability to me in any way for furnishing such information to Inspirien.

I consent for Inspirien to use photocopies of this "Authorization for Release of Information" to present to those persons or entities supplying information as provided herein. Each photocopy is to be considered an original copy.

Date \_\_\_\_\_ (x) \_\_\_\_\_  
\_\_\_\_\_  
(Applicant Signature)  
\_\_\_\_\_  
(Printed Name)





## Supplemental Claim Information

### Instructions to the Applicant

- a. This form should be completed by the applicant whose signature appears on the Inspirien Insurance Company Professional Liability Insurance Application.
- b. One of these forms should be completed for each claim or incident in which the applicant has been involved. If additional forms are needed, applicant may photocopy this form for use in reporting other claims.
- c. If space is insufficient to fully provide answers to the questions below, use reverse of this form or separate sheet.
- d. Answer all questions completely. Complete information is necessary for the equitable and careful evaluation of your application.

1. Full Name of the Applicant \_\_\_\_\_
2. Full Name of the Individuals(s) of your firm involved in this claim \_\_\_\_\_
3. Full Name of the Claimant \_\_\_\_\_
4. Age \_\_\_\_\_ 5. Sex \_\_\_\_\_
6. Indicate whether this was a \_\_\_\_\_ Claim \_\_\_\_\_ Incident \_\_\_\_\_ Suit \_\_\_\_\_
7. Date of Alleged Error \_\_\_\_\_ 8. Date of Claim \_\_\_\_\_
9. Additional Defendants \_\_\_\_\_
10. What is the name of the insurer involved in this claim? \_\_\_\_\_
11. What is the insurer's claim number assigned to this claim (if known)? \_\_\_\_\_
12. Description of the claim (please provide enough information to allow for evaluation and use the reverse side of this sheet if necessary)  
Alleged act, error, or omission upon which the claimant bases claim

Description of the type and extent of injury or damage allegedly sustained

If claim is closed, answer questions 13 and 14. If claim is pending (open), answer questions 15 through 21.

If closed:

13. What was the total loss paid including a deductible that may have applied?
14. Was this amount paid subsequent to a \_\_\_\_\_ Court Judgement or \_\_\_\_\_ Out of Court Settlement

If pending (open):

15. What is claimant's settlement demand? \$ \_\_\_\_\_
16. What is defendant's settlement offer? \$ \_\_\_\_\_
17. What is insurer's loss reserve? \$ \_\_\_\_\_
18. What deductible (if any) applies? \$ \_\_\_\_\_
19. Is this claim in suit? Yes No \$ \_\_\_\_\_
20. If claim is in suit, what amount (if any) was asked for in summons? \$ \_\_\_\_\_
21. Who is defense counsel (please include address and phone number if known or available)? \_\_\_\_\_



I hereby understand that information submitted herein becomes a part of and is incorporated with my Professional Liability Application and is subject to the same conditions.

Date \_\_\_\_\_ (x) \_\_\_\_\_

(Applicant Signature)

\_\_\_\_\_

(Printed Name)

